Containing Health Care Costs

A Critical Test of the Public-Private Joint Venture in Health

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As the federal government shifted from its traditional roles in health to the payment for personal health care, the relationship between public and private sectors has deteriorated. Today federal and state revenue funds and trusts are the largest purchasers of services from a predominantly private health system. This financing or "gap-filling" role is essential; so too is the purchaser's concern for the costs and prices it must meet. The cost per person for personal health care in 1980 is expected to average $950, triple for the aged. Hospital costs vary considerably and inexplicably among states; California residents, for example, spend 50 percent more per year for hospital care than do state of Washington residents. The failure of each sector to understand the other is potentially damaging to the parties and to patients. First, and most important, differences can and must be moderated through definite changes in the attitudes of the protagonists.

LEST THERE BE any doubt, we have been and will continue to be a nation whose health care delivery system is substantially private but whose health care financing system is substantially public. This confluence of public financing and private delivery, when understood, helps explain much of the bitterness, misunderstanding and unhappiness that have characterized public and private sector relationships in recent years.

Your author has experienced the professional joys and agonies in both sectors. In this paper I borrow extensively from materials presented in 1979 at the University of Chicago and Harvard University, where I argued that the American people have sought from their government assurances that there would be reasonable access to health care services of good quality regardless of individual economic circumstance. Contrary to conventional wisdom, the professionals and the institutions that can provide these valued human services are, in large measure, I believe, fully committed to that goal. And indeed, I believe most but not all providers are willing to address this goal with a recognition that affordability—mainly costs and the containment of costs—is one vital, indeed integral element in achieving this important national value.

To this end this paper prescribes and accepts a legitimate role of government in health care, highlights cost trends that are important, suggests strategies of more effective collaboration between government and the private sector, and urges greater understanding and responsiveness on the parties that can most wisely deal with health care costs, the private health care organizations and most particularly, private physicians and surgeons whose decisions most directly influence total health expenditures.

The Public Role

A brief historical perspective may be a useful reminder that government has played an active,

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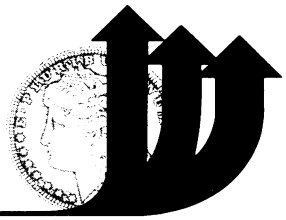


vigorous role in the development of our public and private health care system. In the health sector, government intervention began early with the acceptance of responsibility for public health and the establishment of Public Health Service hospitals. The need for protecting the public's health and safety was obvious and so, too, was the need to provide public health agencies with police powers. Few have challenged this obligation of government.

Following World War II the federal government began extensive funding of hospital construction grants, the first of several "capacity building" activities in health that it undertook over the next three decades. The Hill-Burton Act was an early warning signal that government was shifting toward improving access to acute care services, well-dispersed in small hospital units and presumably attractive to practicing physicians. Congressional proponents concluded that acute care hospitals, under private, voluntary, nonprofit community auspices, would be the cornerstone of community health services. Improving distribution of care by adding private sector capacity became a rational and respectable use of general revenues.

Improving access by building capacity and protecting the public health were two interventions firmly rooted in societal values. So, too, was another notion—the development of the National Institutes of Health (NIH) with the concomitant decision of American political leadership to support biomedical research at high federal funding levels. There was a desire to foster scientific resource development and to maintain international preeminence in science. Stimulating biomedical research was good politics since the flow of achievements, particularly in the post-World War II decade, was quickly transferable to the public welfare.

Charles Schultze, before his current chairmanship of the Council of Economic Advisors, observed that it is never easy but at least possible "to reach consensus on matters involving basic values."[1] In the cases of Hill-Burton and NIH, the political lines were drawn naturally and cleanly because they did involve basic values. "As society has intervened in ever more complicated areas, however, and particularly as it aims to influence the decisions of millions of individuals and business firms, the critical issues have a much lower ideological and ethical content."[1(p89)] The current arguments over energy policy, gasoline rationing and national health insurance are excellent examples of complex policy issues, each with strong countervailing ideologic elements.

Moving from public consensus for hospital construction and bioscientific research to a political consensus for public financing of privately rendered personal health services was more contentious. It took more than two decades to reach a consensus to assist the aged of the nation in meeting their costs of health care. The passage of Titles XVIII and XIX of the Social Security Act depended upon two conclusions that eventually came to dominate the debate. The first was the promise of independence and security for our elderly. The aged could not afford the financial insecurity of major illness (nor could the poor). The second was the conclusion that government had the capacity to manage a carefully planned health insurance program in spite of the incredible range of critical details, the well-orchestrated opposition by certain essential providers and the overall enormity of the task.

The decision to proceed with federal financing for the aged and poor, and eventually the chronically disabled, "the gap-filling" role, contained several important assumptions:

- Medically necessary benefits under the program would be physician-ordered services that relieved discomfort and improved personal health status.
- Public programs would be administered by private insurers in a manner that mirrored their private business. Hospitals would be paid reasonable costs, the common Blue Cross method, and physicians would be paid the lower of their usual, customary and prevailing (UCP) charges to all of the patients.
- Provider participation and beneficiary understanding would take priority over cost.

Some extra administrative latitude was granted to states which contributed matching funds for the care of the poor and medically indigent within their state boundaries.

In 1970 and again in 1972 signs of congressional discontent over cost and quality began to appear. No longer was provider participation a major concern. Physicians and hospitals and thousands of other providers were caring for public beneficiaries at increasing cost to the public treasury. The 1970's saw the birth of health planning, Professional Standards Review Organizations, fraud and abuse units, and reimbursement

ceilings. These statutory changes were among dozens that passed and were sent to the Department of Health, Education, and Welfare (DHEW) for implementation. Many provisions, too difficult politically to settle in Congress, were left to the discretion of the DHEW Secretary.

We health professionals tend to overestimate the level of debate and understanding that is reached in legislative formulation. We want to believe that the legislative process is a deliberative, inquiring and thorough examination of the substance of every phrase, and that the authors themselves are entirely clear in their intent. We believe the consultative process, through public hearings and direct discussion, will assure that legislation is wisely framed, at least before political compromise is imposed. Victor Fuchs, one health economist who has shown some skepticism toward the value of the medical care system in raising the nation's health status, has stated very clearly his conclusions on governmental interventions:

> In my view, National Health Insurance and other governmental interventions in health are best viewed as political acts undertaken for political and social objects relatively unrelated to the health of the population. This seems to be an inescapable conclusion from the evidence now available.[2]

Perhaps now it is clearer why hospital cost inflation was a highly politicized issue for DHEW from 1977 through 1979. The Secretary, recognizing the legislative climate, knew that cost containment legislation could not pass unless the public and their elected representatives reached a collective "political" conclusion that costs were unbearable and out of control. Until that happened the technical details of the proposed law as to whether inefficient hospitals were to be rewarded, whether hospitals had due process, and whether DHEW had too much administrative latitude, were sufficient to thwart the legislative proposal in one house of Congress.

It is not enough to have a technically solid bill. There has to be a serious and believable issue that a majority of congressmen feel certain can be remedied by law. Identifying those issues and having confidence that there are real remedies has led to a stagnated legislative agenda in the current Congress, much to the relief of those content with the status quo.

So far I have identified three roles of government: the public health and safety role, the capacity building role, and the gap-filling financing role of allocating general revenues and payroll taxes to assure needy groups baseline health care purchasing power. It is the latter role that some believe has placed onerous and unreasonable harassing strings on government health care purchases.

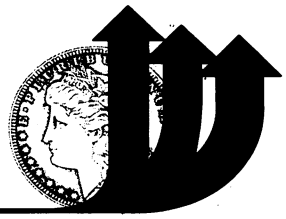
Americans have expected other activities from their government. These include the following:

- *Government as a data gatherer and information dispenser.* This role extends well beyond essential census and vital statistics data. Every major industry, including the health industry, uses government-produced or government-commissioned data.

The growth of informed consumerism in health depends as well on a public familiar with good personal health practices, a public that can comprehend and compare health insurance options, and that is equipped to understand the limits of medical care. As is the case with so many government roles, this is not an exclusive or a preemptory responsibility, but one to be shared with nongovernmental enterprise. Publication of nutritional standards by DHEW and the American Cancer Society's recommendations for preventive checkups are two recent examples of public-private initiatives to inform the public.

- *Government as an experimenter, a demonstrator and an agent of change.* Surely this has to be one of the most useful and innovative roles for government. Health services research, encouraging productivity in the delivery of health care, and experiments in new forms of reimbursement, require federal funding and objective evaluation by dispassionate social scientists. Only those entirely satisfied with the status quo will challenge that as a legitimate public responsibility.

- *Government as a private market protector and stimulator.* For those who lament the vast regulatory machinery that has characterized government's interventions in almost all fields of endeavor, it is paradoxical to suggest that free market preservation is a public responsibility. Yet in almost every aspect of our economy the free and unfettered market depends upon antitrust, antimonopoly legislation to insure the maintenance and growth of a price sensitive marketplace. Curiously, the choice in public policy is not between regulation and nonregulation in health; it is a choice between one form of intervention and another.



In sum our government does have multiple responsibilities in health. Many, including myself, feel these government roles are real, necessary and right for a compassionate, progressive society. What is more debatable is how well these roles are implemented, and whether the government has the demonstrated capacity to fulfill them. Nowhere is the issue more crisply encountered than in the role of financing care for those citizens and residents who cannot meet the costs themselves—the "gap-filling" role.

The Costs of Care

Between 1965 and 1978 national health care expenditures rose at a compounded annual rate increase of 12.2 percent while the gross national product (GNP) rose at 9.0 percent. During the same period public financing of those expenditures rose from 25 percent to 41 percent. Total per person expenses for personal health care rose from $188 per year to $753; in 1980 each person will be spending at the rate of $950 per annum.[3]

Certain responses to these statistics are as predictable as they are painful:

- "What's wrong with a public that spends for health care? Americans simply want more health care and less of other goods and services."
- "Who *knows* what the right health care expenditures percentage of GNP ought to be? And what right have bureaucrats to impose their views?"
- "Everything is escalating—oil, mortgages, etc. Government dollars and patient demands are the culprits in rising health care costs."
- "Hospitals and physicians are ripping off the system, overcharging for many useless or ineffective services."
- "It's technology and defensive medicine. Blame the scientists and the lawyers."

These kinds of responses reflect a sampling of the division within the ranks of buyers and sellers of health services. *They also reflect the disagreement over whether there is in fact a cost problem.* If health costs are not a serious problem, there is little reason to blame any one factor or to find palliatives or cures to problems that do not exist.

To this observer the issue is not whether

- There should be a limit on the GNP share for health (there should not).
- Technology adds costs (some does and some does not).
- Physicians provide unnecessary care (some seem to provide much more care than others; most care is probably effective and necessary).
- Over-bedded hospitals add costs (they do).

The real issue is whether the American taxpayer —you and I—can persuade other American taxpayers that health care in 1980—a substantial part of which government must purchase—is worth the estimated $950 per person. And second, whether we can afford at that average cost to pay for 23 million Americans on Medicaid; and three times that average for the 27.5 million Americans on Medicare who are elderly or chronically disabled.[4]

If the answer is that we cannot easily afford those commitments and perhaps some additional relief for 8 to 10 million Americans at or below the poverty line who have no health insurance, then my view is there *is* a cost problem. If we must begin to sacrifice other valued public services—national defense, aid to education, bioscientific and high energy research, police and fire protection as examples—to guarantee health care entitlements, reasonable persons can only conclude that cost and value in health care are real, rational and very serious public policy problems.

These difficult issues come at a time when the Congress and many states, with a mandate to contain inflation and reduce public expense, must necessarily confront every major item of expenditure. In California, as in many states, the largest single expense is the Medicaid program (Medi-Cal). As is true in all governments, health expenses are running faster than revenue growth. At the federal level we are now spending one of every nine dollars on health care, and that is before 1980 budget cuts for every health program except the Health Care Financing Administration. The task of persuading the private health sector that costs of care are reaching beyond the means of our various governments' abilities to finance health services has often been met with the cry of political overpromise. A more helpful response would be to ask "How can we help? Can costs which are already high be contained? Is the Voluntary Effort (VE) of our major associations a sufficient awakening and response to the cost problems, or can we do better?"

Government, as the single largest purchaser of health services, believes we can do better. It contends that the rate of cost escalation can be

TABLE 1.—*A Comparison of Hospital Costs and Activity in Washington State and California, 1977*[6]

	Washington	*California*
Beds/1,000	3.3	3.8
Occupancy rate (percent)	66.1	66.1
Average length of stay (in days)	5.5	6.6
Admissions per 1,000 population	146	141
Per capita personal income	$7,528	$7,911
Expenses per stay	$1,099	$1,610
Expenses per day	$ 200	$ 246
Expenses per capita	$ 180	$ 260
Expense per capita as a percent of per capita income	2.5	3.4

moderated, not eliminated; in fact moderated further with no loss of quality. The three important allies government needs to effect that ideal are private medical practitioners, health care institutions and informed consumers of health services. The Voluntary Effort is one organized activity that has attempted to form a coalition to moderate costs. Its backers feel that government has not been supportive and, in fact, is skeptical that this effort at self-regulation has had any profound effects on lowering the rate of escalating hospital expenses. Surely we can agree on one aspect. VE was as important as any other single factor in organizing opposition to cost containment legislation and staving off new legislative injunction. Whether the short-term decline in hospital expenditure growth can be attributable to voluntary regulation or state rate review or both, hospital cost increases in 1979 were no longer the aberrant performer in the Consumer Price Index (CPI).

The Voluntary Effort, well motivated as it is, does not address the deeply rooted controllable causes of health care inflation. In a sense the danger of the Voluntary Effort is the probability that it will be the private sector's singular response to rising expenditures. Even in 1978 when hospital expenses rose less than 13 percent and Medicare fees were controlled by a special economic index at less than 6 percent, Medicare costs rose 15 percent from $22.5 billion to $25.9 billion.[5] Of that, Medicare physician services expenditures went from $4.6 billion to $5.5 billion or 16.4 percent. Increases in the number of Medicare beneficiaries from approximately 26.4 million to 27 million account for only a fraction (2.2 percent) of the rise in costs. Is the Voluntary Effort enough? Probably not.

Does the Voluntary Effort seek out differences in hospital costs among states? Not yet. A 1977 comparison of hospital costs and activity in the states of Washington and California (Table 1) is illuminating.[6] Why should hospital expenses in California be so much higher? A 1978 comparison is even more striking. Hospital per capita expense per year or annual per capita hospital expense in Washington was $201; in California, $302—50 percent higher.[7]

These wide ranges in costs suggest that much remains to be done in explaining and indeed, in eliminating unnecessary hospital costs. These extraordinary variations suggest that medical practice patterns may be quite different in the two states. If in fact they are, is it unreasonable that payers in California would want to know what more in benefits they are gaining from their expenditures in California hospitals? Is it unreasonable for Social Security beneficiaries in the state of Washington to ask why so much more of their Trust Fund contribution should be directed into California or other high per capita cost states?

Next Steps

Can there be accommodation between public payors and private care givers in an effort to temper costs? Is it conceivable that what on the one hand is an inherently adversarial relationship between buyer and seller, can be a creative and constructive partnership on the other? The answers are not easily forthcoming. We have sunk to a low point in goodwill between the public and private sectors and a new high in tension and mistrust among the parties. Moreover, the health field is more massive in its dimension and more disparate in its outlook than ever before. Regional surpluses in health and medical manpower are almost as common as current shortages, creating different kinds of insecurities and a new set of economic pressures. How government beneficiaries, the high-risk poor and aged, will fare in a world competing for the healthy patient is quite unclear.

Despite this environment I believe we can get on track to restore reasonable public-private sector relationships. It is essential to do so for there will be an ever increasing interdependence between public dollars and responsive private providers. That suggests to me that the present commitment to intransigent opposition by both parties is not only misguided but dangerous. No one, least of all me, expects two natural adversaries to enjoy wholly common interests and mutual goals. Neither buyer nor seller can invoke "the public interest" as his sole domain.

Failure to achieve mutual compatibility invites the political right of the private provider sector to withdraw and serve only the employed and the wealthy. The growing conservatism of big labor adds plausibility to the prospect. Failure to achieve mutual compatibility invites the political left to push for separate government-operated and directed health organizations. It also encourages more "command-control" regulations upon an embattled private industry. None of these eventualities would be correct for the American public.

The first step—indeed the next step—is to moderate the attitudes of the protagonists. If there is any crisis in health care, it is the lack of private sector understanding of the national condition and government's increasing diatribe against the care givers. The private sector must remind itself constantly that the health care of more than 50 million Americans is financed substantially by government. As the population ages and gaps are filled, the number will increase—I hope not too much. Taxpayers, you and I, and contributing beneficiaries expect that government spending will be prudent and tight, and that at the very least, no blank checks will be issued. We also expect that government will not enrich its contractors unreasonably. The national condition is that government must pay billions for services while simultaneously stimulating efficiency in the health system from which it is purchasing. The private sector must recognize the legitimacy of government's public responsibility and stop resenting its preoccupation with cost, value and quality assurance.

A change in government's attitude is also in order. Federal officials have no appreciation of the "lead-hand" image they have created and the rancor that is caused by endlessly ballyhooing fraudulent practices and health systems deficiencies. Government should engage, not constantly inflame, an industry that can help. If we have inflationary reimbursement and payment programs —and we do—let us deliberate together with industries and professionals in search of viable alternatives. Hospitals, for example, feel that government is castigating them for bed surpluses and poor occupancy. Yet government surely shares the responsibility for the nation's bed supply. Government and health politics are now inextricably entwined, with the result that political opportunism is molding some unfortunate government attitudes. A little old-fashioned high-minded statecraft might restore some order. Most health professionals and hospitals are willing and able to improve our nation's care. Government ought to be willing to accept that assumption. Then, we could begin to whittle away at questionable services and expensive redundancy. We could start real initiatives in reimbursement reform, quality enhancement and health promotion.

In 1972 Anne and Herman Somers wrote:

> We do not have to abandon all of the assets of private initiative to obtain the advantages of governmental financial strength, social equity or democratic control. Nor is it necessary to bind the hands of government to harness the capacities of the private sector in the public interest. We can assimilate both to mutual advantage.[8]

This is where I land. The virtues of both the public and private sectors in health must be discovered and fully savored. There are public and private responsibilities in health care that can only be met through the combined strength of public financing and private care givers. It is not too late for the key players, government and private care providers, to realize that simple but currently elusive fundamental.

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